



Hospital Value-Based Purchasing (VBP) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Reviewing Your Fiscal Year 2025 Hospital Value-Based Purchasing Program Mortality and Complication Measures Hospital-Specific Report Presentation Transcript

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Brandi Bryant: Hello. Thank you for tuning into the *Reviewing your Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report* webinar. My name is Brandi Bryant, and I will be your host for today's webinar.

I would like to welcome our speakers for this webinar. Maria Gugliuzza is the Hospital Value-Based Purchasing Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. Manjiri Joshi is the Measure Implementation and Stakeholder Communication Lead at CMS's Hospital Outcome Measure Development, Reevaluation, and Implementation Contractor. Mike Miller is with the Hospital Quality Reporting Analytics Team.

The purpose of this event is to provide an overview of the Hospital-Specific Reports, or HSRs, for the mortality and complication measures used in the fiscal year 2025 Hospital VBP Program. This includes measure methodology, measure calculations, HSR access, and instructions for submitting a review and correction request.

At the conclusion of the webinar, you should be able to recall the updates to the fiscal year 2025 Hospital VBP Program Mortality and Complication Measures HSR, access and review the HSR, and submit a review and correction request, if desired.

This slide displays a list of acronyms that will be referenced during the webinar. That concludes my introductions. I will now turn the webinar over to our first speaker. Maria, the floor is yours.

Maria Gugliuzza: Thank you, Brandi. My name is Maria Gugliuzza, and I'll be covering topics such as the measures included in the HSRs, the measurement periods associated with those measures, including the impact due to the COVID-19 exception, and other HSRs that are on the horizon.

The purpose of the Hospital VBP Program Mortality and Complication Measures HSR is to provide the underlying claims data that were used to calculate the measure results.

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Using this data, hospitals may review and request corrections to the calculations of the performance period measure rate results prior to those rates being used to calculate a hospital's Total Performance Score.

The performance periods for each of the measures are listed on this slide. On the next slide, I'll discuss why CMS updated the discharge period.

CMS announced that they would not be using claims reflecting services provided in Quarter 1 or Quarter 2 2020; those date ranges being January 1 of 2020 through June 30 of 2020. Quarter 1 was part of the hip/knee complication measurement period initially. Further, CMS is restricting the discharge periods to end on ending October 2, 2019, for the hip/knee Complication measure because the measures identify complications within 90 days of each index stay. Please note that hospitals do not need to request anything to have this exception applied. The updated discharge period has already been applied to all hospitals' calculations that are included in the HSR.

The Hospital VBP Program HSRs were delivered May 9. Following the 30 days after the delivery of the HSRs, you have the opportunity to review the HSR and request a calculation correction. All review and correction requests must be submitted by June 10. Mike will provide instructions and more details regarding the review and correction process later in the presentation.

In these HSRs, only performance period data will be included. If your hospital would like to review your fiscal year 2025 baseline period results, you can download the report through the *CMS HQR Secure Portal*.

This webinar and HSR bundle that you are currently receiving is for the Hospital Value-Based Purchasing Program. The Public Reporting Claims-Based Measures Hospital-Specific Reports are anticipated to be delivered in late April or early May. When the HSRs are available, CMS will provide a notification through the Hospital IQR and VBP Listserve notification groups; full names are listed on this slide.

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If you are not signed up for those Listserve groups, you can sign up using the link available on this slide. We anticipate the Medicare Spending per Beneficiary HSRs will be available to hospitals in May or June of 2024. CMS will provide notification of the HSR's availability through the same Listserve notification groups.

If you have any questions regarding measures, HSRs, and the Hospital VBP Program please submit your question using the [Question and Answers Tool on QualityNet](#). If you experience issues accessing your HSR from the HQR system or requesting and reviewing your HARP permissions, contact the CCSQ Service Center at QNetSupport@cms.hhs.gov. I will now pass the presentation over to Mike Miller. Mike, the floor is yours.

Mike Miller:

Thank you. My name is Mike Miller and I am the HQR Analytics Delivery Manager. Today I'll be walking you through how to get your reports.

Beginning in November 2022, the VBP reports can be downloaded directly from the Hospital Quality Reporting system from the link provided in this slide. The HQR system requires that the user has a HCQIS Access Role, a HARP Profile account, and access to log into MFT.

Once on the HQR website, enter your user ID and password.

Choose the two-factor authentication method that you have set up.

Enter the code that you receive.

Go to the menu on the left side of your screen.

Select Program Reporting on the menu. Then, select Claims-Based Measures.

Select the release year; you will want to select 2024 for the 2025 fiscal year 2025 HSRs. Select the program HVBP and the report. Then, Click on Export.

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New for fiscal year 2024, there are choices within the Export functionality. A minimalist CSV or traditional Excel file are now available. The Excel file represents the legacy report and includes all the tables and summary tabs in a formatted Excel document. The CSV download is for users that wish to utilize the report data in a different tool. The CSV is a zip file of all the tables in the reports, each as a separate CSV and named after the table names in the Excel version of the report.

The Fiscal Year 2025 HVBP HSR User Guide that accompanies the mortality and complication HSRs includes additional information about the data in the HSRs and includes instructions to replicate the complication and mortality measures results using the discharge-level data. That concludes my section of the slide deck. I'll be handing it off to the next speaker now.

Manjiri Joshi:

Thanks, Mike. Hi, everyone. I'm Manjiri Joshi. I am the implementation lead for the mortality and complication measures. Today, I'll be discussing changes that are made to the measures to account for COVID-19.

So, on this slide, we are going to talk about the measure cohort or who was included in the measure. So, as compared to last year, due to COVID-19, there has been no additional changes to the measure cohort for the mortality and complications measures. All the mortality and complication measures in the HSRs for spring 2024 that you will receive will continue to exclude index admissions with having a principle diagnosis of COVID-19. That is ICD-10-CM code U07.1 or a secondary diagnosis of COVID-19, coded as Present on Admission.

Now, we are going to talk about risk adjustment. Same as last year, again, the mortality and complication measures will continue to risk adjust for history of COVID-19. The measure uses one of the four codes that are listed here. The first one being ICD-10-CM code U07.1 as principal or secondary diagnosis on a historical claim. Next, we have the personal history of COVID-19 as a secondary diagnosis on the index or historical claim identified by one of the following codes shown below here. The first one is ICD-10-CM code Z86.16.

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Next is ICD-10-CM code J12.82 or pneumonia due to coronavirus disease. The next one is ICD-10-CM code U09.9 Post COVID-19 condition, unspecified.

Now, we'll talk about the mortality and see how measures handled COVID-19 and the outcomes. There, again, same as previous, there have been no additional changes made since last year. While the mortality measures in the spring HSR that you will receive, COVID-19 cases are not excluded from the outcome. This means that patients who die from COVID-19 within 30 days are counted as deaths in the outcome. These cases are included since the cause of death is not available and thus cannot be excluded.

For the hip/knee complication measure, again, some COVID-19 cases are excluded from the outcome, while others are not. Why? That is because patients who had an admission after surgery for AMI, pneumonia, sepsis, or pulmonary embolism, and have a principal or secondary diagnosis of COVID-19 will not be included in the outcome. However, if the patient has a mechanical or wound complication, surgical site bleeding, or dies, these patients are included, regardless of whether they have or don't have COVID-19. That is back to Mike, again.

Mike Miller:

Thank you. Today, I will be discussing the fiscal year 2025 Hospital Value-Based Purchasing [Program] mortality and complication Hospital-Specific Reports. Let's take a closer look at the contents of the Hospital VBP Program mortality HSR first. The mortality HSR lists the hospital results in the Table 1 with further detail in the tables that follow. Table 1 provides the hospital results for the 30-day acute myocardial infarction, COPD, heart failure, and CABG mortality measures that will be used in the Hospital VBP Program for calculating the achievement and improvement points for these outcome measures. The achievement threshold and the benchmark were calculated on fiscal year 2025 baseline data and are provided here for convenience. The following columns are found in Table 1: The number of discharges is a count of the discharges used for the measure calculations.

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The Performance Period Survival Rate will be used to calculate achievement and improvement points for these outcome measures in the Hospital VBP Program. The Achievement Threshold was calculated as the median survival rate among all hospitals with measure results and at least 25 cases during the fiscal year 2025 baseline period. The benchmark was calculated as the mean average of the top 10 percent of survival rates among all hospitals with measure results and at least 25 cases during the fiscal year 2025 baseline period.

Table 2 includes additional provider-level values that are used to calculate the Performance Period Survival Rate for the AMI, COPD, HF, and CABG mortality measures. Other than the number of eligible discharges and the survival rate, information in this table will not be publicly reported. The following columns are found in Table 2: The Predicted Deaths is the number of predicted deaths within 30 days from admission on the basis of your hospital's performance with its observed case mix and your hospital's estimated effect on mortality. The Expected Deaths is the number of expected deaths within 30 days of admission on the basis of the average hospital performance with your hospital's case mix and the average hospital effect. The replication process, detailed later, will show how the predicted deaths and expected deaths are calculated. The National Observed Mortality Rate is calculated as the number of observed 30-day deaths nationally divided by the number of eligible discharges nationally. Since these are national values, this rate cannot be replicated with the data provided in this HSR. The Risk-Standardized Mortality Rate, or RSMR, is a mortality rate that has been adjusted for difference in the case mix across hospitals and a hospital-specific effect. As shown in footnote [e], the Risk-Standardized Mortality Rate can be calculated with the values found in this table as the Predicted Deaths divided by Expected Deaths, multiplied by the National Observed Mortality Rate. The Performance Period Survival Rate is calculated as $1 - \text{the RSMR}$.

The discharge tables contain discharge-level data for all Part A Medicare Fee for Service, FFS, patient stays with a principal qualifying diagnosis of AMI, COPD, HF, or CABG accordingly, that had a discharge date in the

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reporting period, for patients who were age 65 and above at the time of admission. Some points to highlight as you review your HSR: The ID Number column is provided as a way to reference records while avoiding sharing PII or PHI. The MBI through Discharge Destination columns contain data that were pulled from the hospital claims. The Index Stay column indicates whether the stay is included in measure calculations by a Yes or No. The stays that are flagged Yes represent the discharges found in the Number of Discharges columns in Tables 1 and 2. For stays that are not included in the measure calculations, the Inclusion/Exclusion Indicator column has number(s) 1 through 9, indicating the reason or reasons why the stay was excluded. The corresponding descriptions for these numbered reasons are defined in the user guide that accompanies the HSR.

Continuing on with some additional information, Deaths within 30 days are flagged Yes or No based on if the patient died within 30 days of admission. The Risk Factor variable columns contain the model risk factors, which vary by measure. For each measure, these columns start with the Mean Age Minus 65 risk factor. The risk factors vary for each measure. Table 4 in the user guide provides a description for each. Row 8 in the HSR contains the model coefficients for each risk factor, which are estimates over data for all hospitals. The HOSP_EFFECT represents the underlying risk of a mortality at the specific hospital after accounting for patient risk. Finally, the last column, the AVG_EFFECT, represents the underlying risk of a mortality at the average hospital after accounting for patient risk. Beginning in Row 9 of the HSR under each risk factor column, the cell will contain a 1 if the patient was identified as having that risk factor and equals the years above 65 for the AGE_65 variable and a 0 if otherwise. Values will only display for each index stay that is included in the measure calculations. The risk factor flags will be in cells beginning in Column O.

The replication process for the mortality includes the following steps: One, calculate predicted deaths. Two, calculate expected deaths. Three, calculate the Risk-Standardized Mortality Rate, or RSMR. Four, calculate the Performance Period Survival Rate, or PPSR.

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The user guide distributed with your HSRs includes detailed instructions for replication. An Excel file with sample calculations and step-by-step instructions can also be requested through the QualityNet Inpatient Question and Answer Tool.

To begin the replication process, save a copy of the HSR and complete the calculations in Excel, working below the actual data. The replication steps should be completed on the discharge-level worksheet for each mortality measure. The first step for replicating your hospital's results is to identify eligible discharges. To do this, limit your replication calculations to rows where the Index Stay column equals Yes, using the filter option in Excel.

For each eligible discharge identified, multiply each risk factor flag by the relevant coefficient found in Row 8. Risk factor flags begin with Column N, Years Over 65, Continuous. The formulas used are highlighted in blue on the slide.

Next, sum up all the products from the previous step, risk factor flags multiplied by the coefficient, for each index discharge. This is shown in column BE. The calculation that is shown in the example is for the values in the first row. Next, add the hospital-specific effect, which is the HOSP_EFFECT value found in Cell BC 8, to the sum of the risk factor flags for each index discharge calculated in the previous step. The calculation is shown in Column BF. Please note that this example is for the COPD mortality measure.

Next, calculate the predicted probability of a 30-day death for each stay using the formula shown and the results from the previous step. Please note that EXP in the formula is the Excel exponential function.

Finally, sum the predicted probability of a 30-day death for all of the stays to get the number of predicted deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the predicted deaths value for this measure in Table 2. The example formula shown in blue was used to sum the values for the predicted deaths.

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Each hospital will likely have a different quantity of discharges so the formulas will need to be adjusted accordingly.

To calculate the expected deaths, start with the summed products, risk factor flags multiplied by the coefficient, that were created in the predicted deaths calculations. Add the average hospital effect, which is the AVG_EFFECT value found in Cell BD 8. Next, calculate the expected probability of a 30-day death for each stay using the formula shown and the results from the previous step.

Finally, sum the expected probability of a 30-day death for all stays to get the number of expected deaths within 30 days from admission. When this value is rounded to two decimal places, it should match the expected deaths value for this measure in Table 2. Again, each hospital will likely have a different quantity of discharges and will need to adjust the formulas accordingly.

To calculate the Risk-Standardized Mortality Rate, first divide the predicted deaths by the expected deaths. The result is the Standardized Mortality Rate. Next, multiply the Standardized Mortality Rate by the National Observed Mortality Rate from Table 2 to get the Risk-Standardized Mortality Rate. When this value is rounded to six decimal places, it should match the Risk-Standardized Mortality Rate found in Table 2. The Excel formulas used for the calculations are shown in Column BH. The result of those calculations are shown in Column BI.

The Performance Period Survival Rate is calculated as $1 - \text{Risk-Standardized Mortality Rate}$. When this value is rounded to six decimal places, it should match the Performance Period Survival Rate found in Table 2. The Excel formula used for the calculation is shown in Column BH. The result of the calculation is shown in BI. Due to differences in rounding between SAS and Excel, there may be minor differences at the fifth and sixth decimal places. When CMS calculates your hospital's rates, it uses SAS Viya. The values in your HSR are based on these SAS calculations.

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Now, I will discuss the fiscal year 2025 Hospital VBP Program complication HSR.

Similar to the mortality HSR, the complication HSR lists your hospital's results in the first table with further detail in the later tables. The following columns are found in Table 1: Number of Eligible Discharges is a count of the discharges used for the measure calculations. The Risk-Standardized Complication Rate will be used to calculate achievement and improvement points for this outcome measure in the Hospital VBP Program. The achievement threshold was calculated as the median complication rate among all hospitals with measure results and minimum case size, greater than 25, during the fiscal year 2025 baseline period. The benchmark was calculated as the mean of the top decile of complication rates among all hospitals with measure results and minimum case size, greater than 25, during the fiscal year 2025 baseline period.

Table 2 includes additional provider-level values that are used in the calculation of the Risk-Standardized Complication Rate. The following columns are found in Table 2: The Predicted Admissions with Complication is the number of predicted admissions with a complication within 90 days from admission, based on your hospital's performance with its observed case mix and your hospital's estimated effect on complications. The Expected Admissions with a Complication is the number of expected admissions with a complication within 90 days of admission, based on average hospital performance with your hospital's case mix and the average hospital effect on complications. The replication process, detailed earlier, shows how the predicted and expected rates are calculated. The National Observed Complication Rate is the number of observed admissions with a complication within 90 days, nationally divided by the number of eligible discharges nationally. The Risk-Standardized Complication Rate is the Predicted Admissions with a Complication divided by the Expected Admissions with a Complication, then multiplied by the National Observed Complication Rate.

The complication HSR discharge table contains many of the same columns as the mortality HSR discharge tables.

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A stay can appear multiple times on your Discharges tab if the patient had more than one complication for that discharge; however, it is only included once in the calculation of the measure. Similar to the IQR complications HSR, the Additional Complication Record column is used to flag additional complications. In the example seen here, the first two rows are the same index discharge and list the two complication records that are attributed to that discharge. This is easily identified in the Additional Complication Record column, which has a Yes value for the second record.

The discharge table contains further discharge-level data for the complication measure.

The complication field identifies the complication that occurred, AMI, pneumonia, sepsis, surgical site bleeding, pulmonary embolism, death, mechanical complication, or infection. If a patient did not have a complication, it will appear as N/A. The rest of the columns shown here contain specific information pertaining to the listed complication.

The replication process for the THA/TKA Complication measure is the same as the mortality measure with one difference: In the first step, when you limit your replication calculation to rows where Index Stay, Column G, equals Yes, you must also limit it to rows where Additional Complication Record, or Column H, equals No. The rest of the replication process would follow the same steps as those outlined for the mortality measures.

Now, I will discuss the Hospital VBP Program HSR review and correction period.

The Hospital VBP [Program] review and correction period for fiscal year 2025 is May 9, 2024, through June 10, 2024. Please pay special attention to the review and correction period deadline. Requests sent after June 10, 2024, will not result in a correction.

Review and correction requests can be submitted via email to qnetsupport@hcqis.org or over the phone.

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When emailing a request, please include Hospital VBP Program Mortality Review and Correction Inquiry or Hospital VBP Program Complication Review and Correction Inquiry in the subject line to aid in the help desk process. Review and correction requests can also be submitted through the QualityNet Inpatient Question and Answer Tool. Please ensure you select Inpatient Claims-Based Measures under Program and HVBP Mortality & Complication Review & Correction Request under Topic. Include your hospital's 6-digit CMS Certification Number when submitting your request.

The HSRs contain PII and PHI. Emailing either PII or PHI is a security violation. If you have questions on transmitting data, please contact the QualityNet help desk. If you are referencing a specific case or discharge, please use the ID number found within the HSR rather than sending patient information through email.

Suspected calculation errors on your report can be submitted for review with the possibility of a correction. General questions about the HSRs, mortality measures, or the complication measures may also be submitted. Requests for submission of new or corrected claims are not allowed. A "snapshot" of the administrative claims data available approximately 90 days after the end of the applicable period is taken in order to perform program calculations. For fiscal year 2025, the administrative claims data file for calculations was produced on or around the last week of September. The review and correction process does not allow hospitals to submit additional corrections related to the underlying claims data used to calculate the rates nor add new claims to the data extract used to calculate those rates. CMS cannot regenerate the report for this period to reflect corrected claims. If your facility submitted or wishes to submit a corrected claim after the snapshot is taken that pertained to an incorrect claim originally submitted prior to when the snapshot was taken, the corrected claim will not be included in your measure results. Because claims data are generated by the hospital itself, hospitals in general always have the opportunity to review and correct these data until the deadlines.

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In many cases where the claims listed in the HSRs do not match internal records, it is due to the fact that corrections were made close to or after those deadlines. Thank you for your time. This concludes my portion of the presentation.

Brandi Bryant: Thank you, Mike. We will now answer some of the questions that were submitted during the webinar. If you would like to submit additional questions at this time, please include the slide number associated with your question. The first question is: If my drop-down does not provide Hospital VBP as a selection, is this because critical access hospitals do not participate?

Maria Gugliuzza: Correct. Only subsection (d) hospitals can participate in the Hospital VBP Program. The subsection (d) definition excludes critical access hospitals as well as children's, long-term care, psychiatric, and rehabilitation hospitals. It also excludes hospitals that participate in the Maryland All-Payer model and the 11 Prospective Payment System-exempt Cancer Hospitals. The drop-down only includes providers that participate in the program. Since your hospital is a critical access hospital, you will not have access to any Hospital VBP [Program] reports.

Brandi Bryant: Why does the first selection use release year and not program year? It can be confusing.

Mike Miller: To address potential discrepancies in fiscal year periods across different reports, we use different terms. For example, "release year" is in our user interface to specifically refer to the calendar year when a report is published. However, we apologize for any confusion it may cause when compared to the more appropriate term "program year." "Program year" pertains to the year in which CMS reporting program adjustments are made to payments. We acknowledge the need for clearer terminology and apologize for any inconvenience that this may have caused.

Brandi Bryant: Slide 54: If our critical access hospital received the fiscal year 2025 Hospital VBP Program Mortality and Complication Measures Hospital-Specific Report, or HSR, should we ignore it?

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Mike Miller: Yes, you should disregard the report. CAHs are excluded from the Hospital VBP Program. Therefore, CMS does not provide the report to any CAH CMS Certification Numbers. There are hospitals with acute care CCNs that later converted to CAHs, and it is possible that they received a report. However, CAHs are not included in the Hospital VBP Program and should not consider the report for their evaluation.

Brandi Bryant: What is the difference between Hospital VBP Program Claims-Based Measure, or CBM, HSRs and the Hospital Inpatient Quality Reporting, or IQR, Program preview reports?

Mike Miller: Hospital VBP Program CBM HSRs provide hospitals with detailed information and feedback on their performance in specific measures within the Hospital VBP Program. These reports are confidential and intended for internal use by hospitals to assess their performance, identify areas for improvement, and make informed decisions about quality improvement initiatives. Hospital VBP Program CBM HSRs offer a comprehensive overview of hospitals' performance, including scores, benchmarks, and comparisons with other facilities. Hospital IQR Program preview reports serve as an early assessment of hospitals' estimated performance in that program. Unlike HSRs, these reports are not confidential; they give hospitals an opportunity to review and validate their data before CMS publicly reports the data. Preview reports allow hospitals to identify and rectify any potential data discrepancies or errors before the final data values are published. During a 30-day preview period, hospitals can review their data before it is publicly displayed on Care Compare. In summary, Hospital VBP Program CBM HSRs are detailed internal reports for hospitals to evaluate and improve their performance within the Hospital VBP Program, while preview reports for the Hospital IQR Program provide hospitals with a glimpse of their reported data, allowing them to validate their data before public reporting.

Brandi Bryant: Thank you. How have the cohorts and outcomes for the mortality measures been updated due to COVID-19?

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Manjiri Joshi: The mortality measures exclude index admissions with a principal diagnosis code of COVID-19, that is ICD-10-CM code U07.1, or with a secondary diagnosis code of COVID-19 coded as POA on the index admission claim from the measure cohorts. The mortality measures outcome has not been updated due to COVID-19 because the cause of death information is not available.

Brandi Bryant: Where can I find the code specifications used to exclude readmissions with COVID-19 from the THA/TKA complication outcome?

Manjiri Joshi: You can find these code specifications in Table 6 in the 2024 THA/TKA Complication Measure Supplemental File. That is available on QualityNet in the Methodology section on the Complication Measure page. It is also important to note that readmission claims with COVID-19 coding are only excluded in determining the following four complications: acute myocardial infarction, pneumonia and other respiratory complications, sepsis/septicemia/shock, and pulmonary embolism. These outcome exclusions are further discussed in Sections 2.2.2 and 3.2.2 of the 2024 Procedure-Specific Complication Measure Updates and Specifications Report. Again, that is also available on QualityNet, right next to the supplemental file.

Brandi Bryant: It looks like that is all the time we have for questions. If your question wasn't answered and you still have questions regarding measures, HSRs, or the Hospital VBP Program, please submit your questions through the question and answer tool on QualityNet. Thank you again for joining. We hope you have a great day.